BUILDING PARTNERSHIPS: HOW TO MAKE IT HAPPEN

Minnesota *Decides*: a community blueprint for tobacco reduction

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The national tobacco landscape is rapidly changing as a result of federal policy reform; action is taking place at the state level as well. During the past year, I have had the privilege of directing a state project called "Minnesota *Decides*: A community blueprint for tobacco reduction". This project has led to the creation of a statewide action plan for addressing tobacco use. This plan is influencing the debate over how to steward state tobacco settlement dollars. To date, outcomes include goals and action steps that are being embraced in various settings across the state as set forth in the plan by a cross section of Minnesotans. What makes this project different is the unique blend of public and private cooperation and input that led to its creation.

Tobacco use in Minnesota remains at epidemic proportions, according to the Minnesota Department of Health. One in every six deaths is tobacco related. Nineteen Minnesotans die every day as a result of tobacco use. Annual direct and indirect costs are estimated at more than $1.3 billion. For a state that prides itself on the health of its citizens, it is very disheartening to know that 42% of students in grade 12 (age 17–18 years) smoke on a regular basis. Tobacco use clearly is a major concern among Minnesotans—a concern no longer limited to public health. Health plans (such as Blue Cross and Blue Shield of Minnesota), health care providers, educators, law enforcement agencies, local government agencies, communities of faith, the non-profit sector, and businesses in Minnesota are increasingly invested in the problem.

Minnesota *Decides* is a public/private response to this broad base of concern about the tobacco epidemic. It is also a response to an opportunity. Because of tobacco's changing political landscape in this country, we now have an opportunity to change the culture of tobacco, starting with our own state. In Minnesota, even before our successful lawsuit, there was evidence that the tobacco industry was beginning to lose its influence. Two years ago, after years of work by the tobacco control community, significant youth tobacco access legislation was passed. We began to hear from new voices, and organisations began to express their outrage over the grip tobacco has on our culture. For example, health plans in Minnesota lobbied hard for passage of the youth access bill. Many other organisations that had not been a part of the tobacco debate began to weigh in. We're also experiencing a surge of support thanks to the tobacco lawsuit that was announced in August of 1994 by co-plaintiffs Minnesota Blue Cross and the State of Minnesota. (The suit was subsequently settled on May 8, 1998—a striking victory over "Big Tobacco".)

Minnesota *Decides* had a threefold purpose: (1) to create a public/private partnership; (2) to increase the number of stakeholders involved in the issue; and (3) to develop a state plan of action for tobacco reduction.

A public/private partnership

Blue Cross saw its role as convening this effort, but we recognised from the outset that we could not own the project. Our objective was to create a public/private partnership that would contribute the necessary resources, skills, and clout. As we built this project, we saw the value of having shared decision making, responsibility, and accountability. Ultimately, the project partners included Blue Cross, the Minnesota division of the American Cancer Society, the Minnesota Smoke Free Coalition, the Association of Minnesota Counties, and the state of Minnesota, represented by the Departments of Health and Human Services and the attorney general's office. When offered the invitation, each group enthusiastically jumped on board. Funding for the project was provided by a grant of $138 000 from the Blue Cross and Blue Shield of Minnesota Foundation.

Broader stakeholder involvement

The project was very grass roots in nature, beginning with local community involvement. During the summer of 1997, 10 community meetings were held around the state of Minnesota, in both metropolitan and rural areas. Our goal was to have meaningful dialogue during those town meetings, so we limited participation to 40–60 people. We wanted to hear from people who had not previously participated in a public dialogue about tobacco control. We worked hard to see that the right people were in attendance. We wanted to attract smokers and non-smokers. We wanted to have different sectors of the community represented. Health care and public health officials were invited, but we also wanted to hear from members of law enforcement, local government, education, communities of faith, communities of colour, and youth and parents.

The business community was the other constituency that was important to involve. Business' stake in tobacco's economic equation

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is high. According to Minnesota Department of Health research, more than $766 million was spent in 1995 on lost work productivity resulting from tobacco use. Despite this fact, except for opinions expressed by tobacco retailers, the voice of Minnesota business was seldom heard on tobacco issues. To bring members of the business community to the table, we worked with individuals from local chambers of commerce, who served as meeting hosts and helped to secure business participation.

A significant challenge during town meetings was to limit the number of local public health staff and tobacco control volunteers in attendance. Their opinions are extremely important, but in order to ensure the proper dialogue, we needed to broaden the base of involvement yet limit the number of participants.

The town meetings were two hours long and were usually held during lunch. They featured both presentations and discussion. Presentations included the "state of the state" of tobacco use in Minnesota, featuring tobacco use trends and a recap of state tobacco control activity. Then a panel—typically including a county public health staff person, a health care provider, and a law enforcement official—discussed tobacco use and control at the local level. Participants then engaged in what was often a lively, and occasionally heated, discussion about what should be done to address the problem of tobacco use. Suggestions were numerous and ranged from simple to complex. Through these discussions over the course of the summer, we systematically collected information about what people thought about tobacco reduction around the state. After each town meeting, a report was written that provided a synopsis of what was said. Participants received the report, as did the local media.

By the end of the summer, more than 400 Minnesotans had had the opportunity to express their opinions and suggest solutions. Our goal—to increase the number of stakeholders involved in the issue—had been accomplished; 60% of participants had not previously engaged in a public discussion about tobacco.

Plan of action

Although ideas discussed at the town meetings were varied and diverse—ranging from banning tobacco products altogether to strengthening enforcement of existing laws and establishing worksite smoking policies—the consensus was that a broad based approach was needed. Minnesotans, by and large, recognised the need to change community tobacco norms.

The next phase of the project was a statewide summit, which took place in November 1997. During the period between the town meetings and the summit, we collected tobacco reduction best practices, both in Minnesota and across the country. We looked at the experiences of California and Massachusetts. We also went to 50 different Minnesota organisations and asked them to define an appropriate statewide goal for tobacco reduction. All of that information, coupled with the findings from the 10 town meetings, was brought forward during the two day state summit. More than 100 state leaders attended. Participants included senior officials from state government, law enforcement officials, business personnel, educators, members of communities of faith, individuals from communities of colour, and individuals from the health care community. We brought these people together to participate in a working conference with the objective of developing a blueprint for tobacco reduction.

Interactive audience polling technology was used to give everyone an equal voice. Issues or potential solutions were raised and participants anonymously expressed their opinions. By the end of the first day, participants had agreed on a three part goal for the blueprint: (1) to prevent a new generation becoming addicted; (2) to help smokers who want to quit; and (3) to protect Minnesotans from the impact of secondhand smoke.

On the second day, small groups worked toward finding common solutions. These groups were organised according to the following six settings for tobacco reduction, as described by the National Cancer Institute: worksites, points of access, schools, public places, health care settings, and the home.

By the end of the summit, recommendations were established for each setting. For example, for the health care setting, the recommendation is that providers need to be trained to assess, diagnose, and treat tobacco addiction, and payers need to reimburse for proven smoking cessation treatment. The summit also addressed how the various recommendations could be financed, most notably through an increased tobacco excise tax and from pending state tobacco settlement funds.

Progress to date

Following the summit, a 72 page blueprint for Minnesota tobacco reduction was produced. The document incorporates the findings of the town meetings, the recommendations from the summit, and the best practices and suggested goals submitted by Minnesota organisations. After a statewide media launch in April 1998, the plan was widely distributed. Thousands of copies of the plan and its executive summary have been disseminated to Minnesotans as well as to organisations nationally. One important audience was Minnesota policy makers; the blueprint is helping to shape the current debate over how the Minnesota legislature should appropriate state tobacco settlement proceeds. Other states have also referred to the blueprint as they pursue their own plans of action following the national tobacco settlement.

Beyond the actual plan, several outcomes have been achieved. First of all, Minnesota now has a lot more people invested as stakeholders in this issue—people who are informed and concerned, and who are interested and willing to be involved in this issue. Several communities used the Minnesota *Decides* town meeting as a springboard for their own local activities. For example, after the meeting in Winona, a southeastern Minnesota community

of 27 000, the community got behind a grassroots initiative around tobacco. Over the course of several months, community members developed a program called TNT—Trash Nicotine Today. Winona schools, health care providers, parent organisations, the police department, the local college, and others are involved. The program sets an aggressive tobacco reduction goal and includes measures to monitor success. (For more information, go to www.winonahealthchallenge. org)

Where do we go from here? We are currently building on the success of this project by converting the state plan into areas of sustainable action. Blue Cross is supporting a series of grassroots community mobilisation efforts across Minnesota. We are also helping to develop an assessment instrument that will be used later this year to aid Minnesota communities to determine their readiness to change local norms about tobacco.

Minnesota *Decides* offers a strong message: Minnesotans want tobacco's grip on our culture to change. With the right resources, we can succeed.

For more information on Minnesota *Decides*, visit our web site at: www.mnbluecrosstobacco.com

Questions and answers

Q: What is the best way to approach a managed care organisation in order to generate interest and get them involved? Who are the best people to involve?

A: Managed care organisations are beginning to take seriously their role to reduce tobacco use. The stakes are simply too great to ignore. The Minnesota *Decides* blueprint defines appropriate roles for health care organisations to play, including managed care organisations. The obvious first course of action for managed care is to consider what it can do to help its smoking customers to quit, starting with offering a cessation benefit. Health plans are also demonstrating leadership in worksite cessation, community prevention, youth education, counter-advertising, public policy, and grassroots organising. The advent of state tobacco settlement resources to managed care will be a motivating factor, but not the only justification for embracing tobacco reduction strategies.

Start at the top, with the chief executive officer or chief medical officer. Reducing the tobacco epidemic means reducing costs and saving lives—two priorities high on the list of every managed care executive.

Strategic partnerships for addressing tobacco use

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The issue of partnerships in tobacco control is particularly important as we work to incorporate tobacco cessation and intervention into health care and other community settings. As we learn to work together in more effective ways, partnerships among multiple agencies and in communities become increasingly critical. In fact, it is through partnerships that we will ultimately achieve our goals.

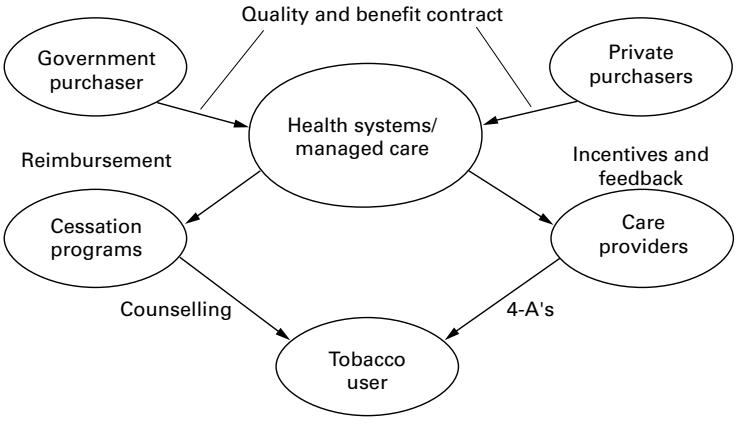

Figure 1 Oregon tobacco cessation project vision.

Background for addressing tobacco in Oregon's health systems

In 1995, the Tobacco Free Coalition of Oregon (TOFCO) published a 10 year statewide tobacco prevention plan which outlined five goals for reducing tobacco use in the state of Oregon. The second goal in this plan is to treat tobacco dependence primarily by incorporating tobacco intervention into routine health care. The rationale for this approach was based on research that demonstrates the effectiveness of provider based cessation programs and data that suggests that 70% of smokers see a health care provider every year. TOFCO believed that finding ways to integrate tobacco use prevention into routine health care could have an impact on reducing tobacco use across the state.

The health systems task force of TOFCO was convened to develop likely approaches to accomplish this goal and to discuss possible strategies. Since more than half the population in Oregon is insured through managed care, we focused on ways to approach managed care organisations.

The "tobacco intervention project" was the subject of lengthy, and sometimes discouraging, strategic discussions by the health systems task force over two years. While the overall